SINGAPORE MEDICAL ASSOCIATION

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EDITORIAL

The Asian Pacific Congress of Cardiology

From time to time regional international medical conferences are held on various medical disciplines in our region and these punctuate and highlight the progress of contemporary medicine in our area.

One of the earliest international regional conferences was on Pediatrics some years ago, and since then, conferences on Ophthalmology and Obstetrics and Gynaecology were held with outstanding success. The latest of series was the Asian Pacific Congress of Cardiology. Naturally every thinking member of our profession would like to pause, ponder and reflect on its real and ethereal benefits to our profession, to the cardiologists and to the people in general in our region, after the fanfare, bustle and dust of these international conferences have settled down.

Undoubtedly cardiovascular diseases are one of the biggest causes of morbidity and mortality, if not the biggest cause in our rapidly developing urban and industrialised society. So quite naturally our people have a vested interest to know, how they can benefit either directly through more enlightened medical attention or indirectly through community schemes that emphasize the modern trend of prevention of cardiovascular diseases.

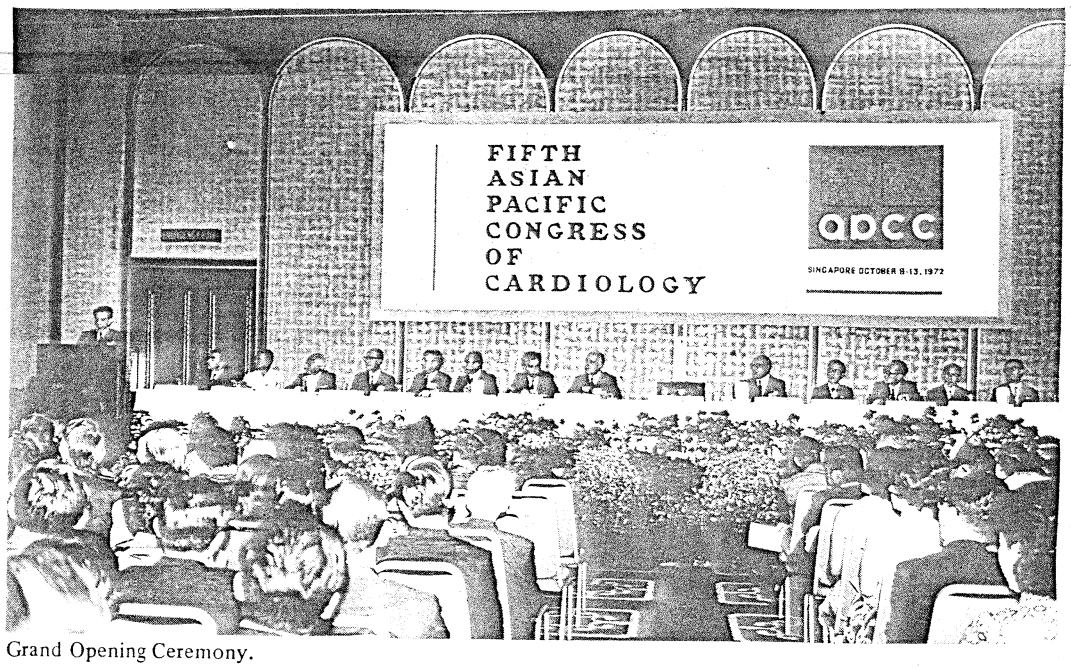
One would like to see a round-table conference called by the Cardiac Society of all interested parties including Ministry of Health officials to do a "post-mortem" on this Congress, to critically and objectively evaluate all scientific data presented from

(i) The pure scientific aspect.
(ii) Its feasibility of application to community projects from epidemiological and preventive aspects.

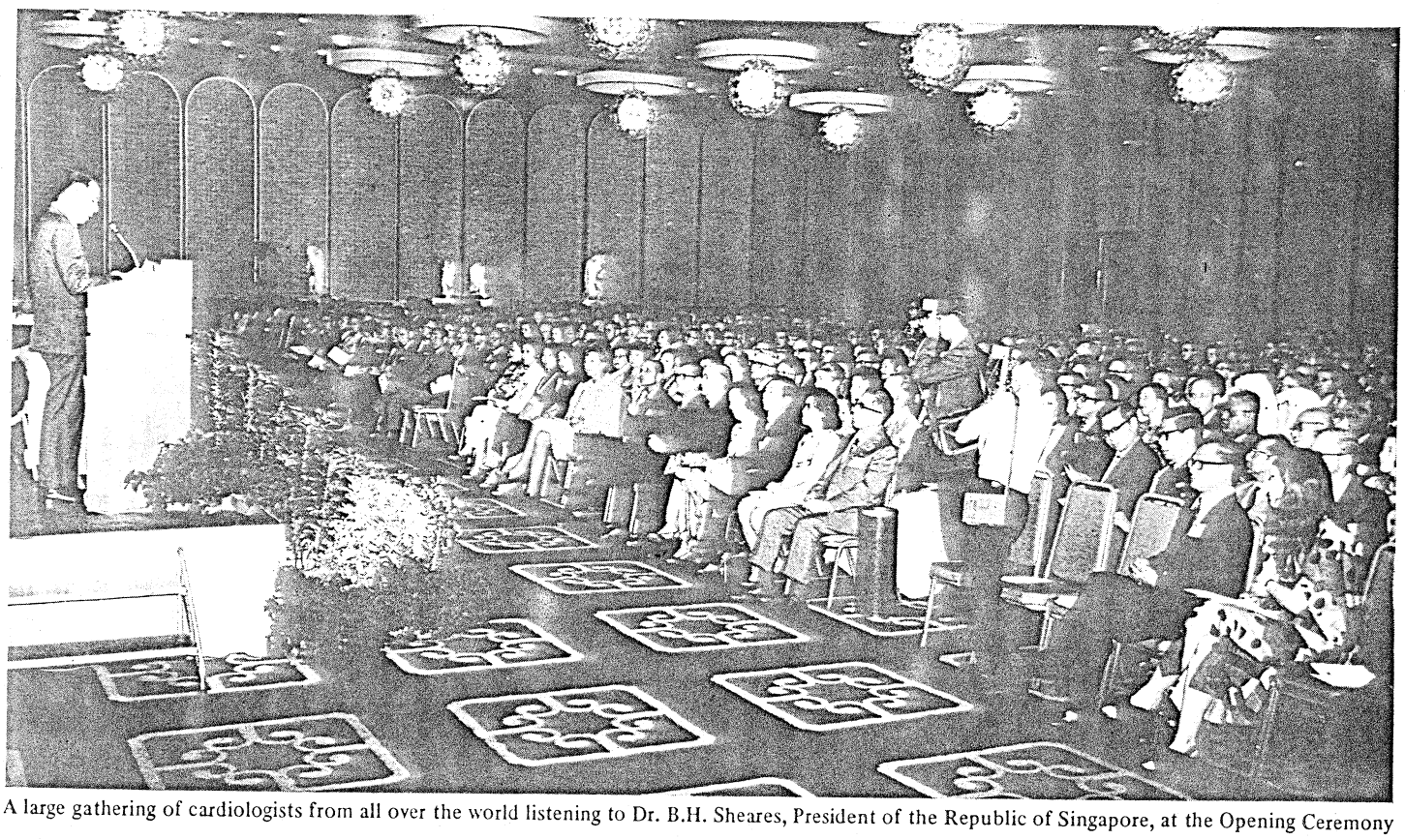
From the pure scientific aspect it is difficult to be dogmatic and generalise as most of papers presented were on the frontiers of knowledge and therefore by its very nature controversial. However, the general pattern discernible was an emphasis towards preventive cardiology and cardiac surgery. These twin modern trends should be highlighted and emphasised with particular reference to local conditions by a team of local experts and given as refresher courses or synopsis to various sectors of the medical profession so that these recent advances in medical knowledge will permeate down to the people for their ultimate benefit. To ensure that this idea is fully implemented it is essential to get the full co-operation and participation of all interested sectors of the medical profession including the Cardiac Society, National Heart Foundation, Academy of Medicine, College of General Practitioners and other interested parties. It should never be forgotten that the frontline man, the family physician/general practitioner who deals with the general population at large should be fully briefed so that the general population will ultimately benefit from these recent advances and trends in cardiology.

In the field of epidemiology, natural history of different types of heart diseases and prevention, the patterns around the world significantly differ, according to geography, socio-economic level and racial groups. Gone are the days when all acquired heart diseases were generally attributed to degenerative conditions and the inevitable consequence of ageing. On the contrary many of them are manifested or have their roots in childhood, although there are several critical periods throughout life, and the frequency increases with age. With spectacular advances in molecular biochemistry and immunology, many of these so called degenerative heart diseases are really derangements of the finely tuned and balanced dynamic biochemical reactions within the body which do not manifest as clinical diseases until after a variable interval (sometimes

● See page 8.



Grand Opening Ceremony.



A large gathering of cardiologists from all over the world listening to Dr. B.H. Sheares, President of the Republic of Singapore, at the Opening Ceremony

Practical Problems in Medicine

Toxaemia of Pregnancy

— Prof Lawrence Chan

This syndrome characterised by oedema, hypertension and albuminuria is present with us still and complicates about 5 per cent of pregnancies in Singapore. The aetiology still eludes us; it is not due to any toxin and the basis is probably multifactorial. The name is now changed to "Hypertensive disorder of pregnancy" and this includes pre-eclampsia and eclampsia, essential hypertension associated with pregnancy and chronic nephritis complicated with pregnancy. When hypertension i.e. blood pressure of 140/90 mm.Hg. or over is detected in pregnancy the risk of death to the baby is about 1 in 20 and that for the mother is about 1 in 500. With good medical care these risks can be reduced.

Diagnosis:

Patients should receive ante-natal care regularly from about the 3rd or 4th month of pregnancy. This aspect of health education needs to be stressed to pregnant patients. Hypertensive disorders of pregnancy, manifests itself by signs (hypertension, oedema, albuminuria) rather than symptoms (headaches, giddiness, blurred vision, epigastric pain) which occur when the disease is in its late stages just before convulsions occur. It is interesting to note that 4 of the 6 things done at each ante-natal visit (weight, blood pressure, urine for albumin, testing for oedema; the other two being urine for sugar and abdominal palpation) are to detect hypertensive disorder. The most important of the signs is hypertension i.e. a casual blood pressure of 145/90 mm.Hg or more with or without oedema or albuminuria. Once the diagnosis is made EARLY treatment is essential to prevent the condition from deteriorating. The patient should be referred to an obstetric unit for admission to hospital immediately or the next day.

Treatment:

The treatment in hospital can be summarised as follows:

A. **General and Symptomatic**

i. Rest in bed preferably lying more on the side rather than supine to improve blood flow to the uterus. The patient can be up to toilet.

ii. Mild sedation with Tab. chlordiazepoxide (librium) 10 mgm tds and 30 mgm o.n.

iii. A normal diet. Salt restricted diet of 2 gm. per day is given for a few days if the oedema is marked.

iv. Diuretics if the oedema does not settle with bed rest.

v. Hypotensives if the diastolic blood pressure does not settle after 48 hours to 90 mm.Hg. or less.

B. **Observation of Maternal and Fotal well-being**

(a) A hypertensive disorder chart is kept in which the patient's blood pressure is recorded twice a day. The urine is tested daily for albumin. The daily urine output is recorded and maternal body weight noted twice a week. By this means the progress of the disease can be plotted.

(b) As regards the foetus clinical assessment of baby size and increase, amount of liquor amnii, and twice a week uterine fundal height and girth are noted. These are supplemented by 24 hour maternal urinary estriol estimation carried out once or twice a week to assess the feto-placental well being.

C. **Termination of Pregnancy**

At the opportune moment when the foetus is estimated to be mature, i.e. about 38 weeks and has good chances of survival, pregnancy is terminated usually by surgical induction of labour. Sometimes the obstetrician's hand is forced to intervene earlier either because the hypertensive disorder is worsening and uncontrollable or the placental function is insufficient with risk of intra-uterine death. Once the baby is delivered, the hypertension immediately settles to normal in the majority of instances, excepting those patients with essential hypertension or chronic nephritis.

The watch words for management of hypertensive disorder in pregnancy is Early detection, Adequate treatment and Judicious delivery of the fetus.

(Not to be Quoted in the Press)

P.M.A. Convention

The Philippine Medical Association will be holding its 66th Annual Convention from April 25-29, 1973. The theme of the convention will be 'Medical Progress through International Co-operation'.

Members who wish to attend this convention are asked to submit their names to the SMA Secretariat.

Combined RACGP & CGP Meeting

The College of General Practitioners (Singapore) has announced that they will be holding a combined meeting with the Royal Australian College of General Practitioners in Singapore from September 1-5, 1973. Further details will be announced at a later date.

Unquotable Quotes

by Amen
(a consultant)

MEASUREMENT OF A WELL-TO-DO G.P.

NOT the length of his degrees,
NOR the depth of his knowledge,
BUT the weight of his purse
AND the volume of his grease.

THE HEAT

Heat rises with her soaring hem,
And flares with his falling locks.
It glows in some dark, unsmiling lands
Where mights are red and right.

LETTERS Not to be quoted in the press

Grouses - Getting an I.Q. Test

Dear Editor,

A formal I.Q. test is often-times helpful in resolving some diagnostic problems seen in clinical practice.

Basically it is a testing or diagnostic procedure and is best undertaken by a psychologist conversant with it. In effect the results are very similar to other diagnostic procedures as biochemical investigations, microscopic and X-ray examinations, E.E.G. and E.C.G. run-offs etc, in confirming or otherwise clinical impressions.

With regard to tests other than that for I.Q., an application is made by the referring doctor to the head of the unit or department concerned; an appointment made; the test carried out; the results given and the charges paid.

The results may be given by a technician (as in urine F.E.M.E.) or a highly specialised expert (as in angiographic studies).

Either the technician or the highly specialised expert may discuss with the referring doctor the clinical aspects of the patient and even examine the patient on occasions but this is almos invariably limited to either a closer appraisal of the risks involved in the examination procedure, if any, or to a need for a better understanding of the clinical problem due to unexpected results.

At no time (one hopes) do discussions centre around possible spurious referrals. The judgement of the referring doctor is normally unquestioned unless special reasons merit a reconsideration otherwise.

Of course if there are limitations in providing for an adequate service e.g the recent breakdown of the E.E.G. machine, then the appointment is deferred to a later date.

With regard to I.Q. tests the procedure as set out by the Ministry is as follows.

An application is made to the consultant psychiatrist at Woodbridge Hospital, in charge of the psychologist. The patient is then subjected to a full psychiatric examination whereafter he is referred to the psychologist to do the I.Q. test. The results are given to the psychiatrist who then incorporates them with his psychiatric report and delivers that to the referring doctor. A psychiatric consultation fee of $35.00 is chargeable.

It would appear to me that the unsolicited psychiatric consultation is a total waste of valuable time by a senior professional personnel.

The patient is sometimes embarrassed (and so are the relatives) in having to divulge information which they have to do to a doctor not of their choice. This is particularly so as psychiatric material is not uncommonly of a rather private nature.

By analogy it would be like having a radiologist requested to do a chest X-ray, clerk the case all over again before instructing his radiographer to proceed with the chest X-ray.

Finally, it remains to be said that with the deepest of respect to the consultant psychiatrist, the unsolicited psychiatric opinion may be variable or contrary and therefore unacceptable to the referring doctor, who may be a psychiatrist himself or a paediatric, neurologic or other specialist who may have need for an I.Q. test and an I.Q. test only. Occasionally this variable or contrary opinion may even disturb the referring doctor's relationship with his patient should this variable or contrary opinion be unnecessarily or inadvertently made known to the patient.

In consideration of the above may I therefore suggest that this unsolicited psychiatric consultation be dispensed with.

Dr. Wong Yip Chong

Ah Wun, he say.....
Them doctors condemn self-medication.
Don't them doctors self-medicate?

Some Aspects of Donors & Recipients

by
a surgeon

The two topics in the limelight are "Trauma" and "Renal" Transplants". It is an undisputed fact that vehicular traffic in Singapore has increased tremendously over the past few years. One would expect also a corresponding increase in traffic accidents and its attendant casualty and, even worse, mortality rate. However it is a source of wonder that the comparatively well disciplined population (as witness the title "Cleanest City") should have so many jaywalkers.

Walk into any surgical ward and you will see any number of "pedestrian knocked down by motor vehicle" injuries. The reason for this is not difficult to fathom.

Go into the City, and you will find pedestrians walking or hurrying against traffic lights. Look at an overhead bridge, and you will find more people crossing below it than over it. One even encounters a breed that uses the road as a lounge or a club-house.

There are many instances where children and adult alike dash across a busy street only yards from a traffic light or a zebra crossing, with a policeman looking passively on.

For a disciplined nation we are lamentably short on commonsense and consideration for other road users. Legislation should be introduced along the same lines as in the "Keep Singapore Clean" campaign. Tickets should be issued on the spot for jaywalkers and pedestrians who do not observe traffic regulations. Only then will we be able to reduce the number of casualties and ease the strain on our overburdened hospitals.

The glamour of Renal Transplant is still very much in the Public's mind – but it is something which should not be allowed to come to the operating table. In short it is a last ditch attempt to replace kidneys damaged through neglect or ignorance. That the large number of such patients are brought to light is an indictment against the public for not seeking treatment earlier, and the medical profession for not detecting and treating them earlier. In many cases, preventive measures will reduce damage to the kidneys. The "phenacitin" kidney is a case in point. The patient takes dozens of the apparently innocuous pain killing tablets containing phenacitin over a period of years, and eventually destroys his kidneys, so that expensive dialysis programme have to be started pending the search for a suitable donor. Children with fever are not investigated fully but are given antibiotics, the panacea for all infections. Pregnant and post-pregnant women are treated with long term urinary antiseptics with no concerted attempt to investigate their underlying cause.

The best approach to irreversible renal disease is not to

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The Medical (Therapy, Education & Research) Act 1972:

A Doctor's Point of View

by DR. CHAO TZEE CHENG

Stepping into the era of transplantation, Singapore has found the old Medical (Therapy, Education and Research) Act inadequate. The old Act, modelled upon the Human Tissue Act 1961 of Great Britain contained a number of ambiguities as in the model Act. Terms such as 'person who is in lawful possession of the body', 'any surviving relative' and 'having made such enquiries as may be practicable', are themselves under review in Great Britain. The Report from the Advisory Group appointed by the Health Ministers says:

"In the period between death and the claiming of the body by executors or next of kin, is it the hospital, or does possession of the body by executors or next of kin start at the moment of death? Is it permissible under the law to remove organs if no enquiry is 'practicable' within the very short time after which organs become unusable? Does the right to object subsist literally in 'any surviving relative', no matter how remote the kinship? Is the Coroner or Procurator Fiscal obliged to require that organs not be removed until his own duties can be carried out?"

The time is ripe for reform. Medical science has advanced to such a stage that it is possible to prolong life and improve upon diseased conditions by the transplantation of tissues and organs from living or deceased donors. Blood transfusion is the commonest form of transplantation of tissue from a living donor. Here the donor gives his consent voluntarily and freely, his wish is not hampered by 'any surviving relative', and the donee is often an unspecified person. In such cases, the consent is deemed valid because it is given by a competent adult person of sound mind. The society has approved of this practice, in fact, it is positively encouraging people to be donors. When it comes to large organs such as the kidney, though it can be obtained from a live donor as it is a paired organ, many practical problems arise. There is no question legally as free and valid consents are always sought. But there is the ethical question of leaving the donor with only one functioning kidney, though it is adequate in normal times, it becomes inadequate in times of stress or disease, thereby reducing his chances to recover and there is always a risk, though small, in any operation. More important is the psychological attitude the donor may develop, that the donee owes his life to him, and this has made life miserable for both parties. There is also the mental stress and pressure suffered by the potential donor imposed upon by relatives, sometimes leading to donation by force. The feasibility of removing organs such as the heart, lungs and kidneys from newly deceased persons for transplantation has solved these problems but given rise to new ones. The definition of death, and objections from relatives, are points in issue. It is felt that the wish of the donor to donate part or all of his body upon death should be held as having primacy over and not frustrated by

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Specialist Accreditation

What's the Fuss, Baby?

by

Dr. Un Hon Hing

For some time the Council has been aware that doctors in Singapore have been gaily accrediting themselves as specialists in this and that field without much rhyme or reason. Obviously, before the Council can condemn or condone such practices, it must first agree on what constitutes a specialist, and who, if any, is entitled to be regarded as one. The Acreditation Committee was thus appointed with these two aims in view. There is nothing mysterious or improper in such a move.

Conceivably, in its enthusiasm, the Committee may stray beyond the terms of reference. The Council has adequate machinery to deal with such a situation.

It is strange that an axiomatic statement by Dr. Fung, the Chairman of the Committee, that 'only when we have proper accreditation can we have a proper Register of Specialists,' should have generated so much heat and agitation. Every member, including Dr. Fung, should have the right to express an opinion on the close relationship between the work of the Accreditation Committee and the unwanted Register of Specialists. There is nothing improper in such an opinion. Similarly, every member, including Dr. Fung, should have the freedom to express the wish, which in fact he did not, that a Register of Specialists will eventually be formed as a result of the deliberations of the Committee. There is nothing sinister nor binding in this either.

Unfortunately, to many in Singapore, to wish is to commit. To those highly imaginative custodians of our constitution, a thought is as good as a deed, and a desire as final as the act itself. Not surprising, far too many have been condemned in Singapore on presumption and not on fact.

What is even more alarming is that members have condemned the Accreditation Committee long before the Committee had even started writing its report. Like the imperious tyrants of old and those madmen after them, they cry, 'ABORT' long before the babies were even conceived.

It is quite clear the charges of plots and conspiracies, violations of the constitution and arrogant defiance of the mandate of the AGM are all completely unfounded.

Teratogenic monsters are only conceived by those who cannot separate fact from fantasy. Fortunately for them, self-abortion is now possible with the aid of Prostaglandin. May their purgations be painless and complete.

Chess Notes by National Master Lim Kok Ann

Singapore Second in Group D

Due to early reverses the Singapore Team qualified (for the third time) for Final Group D, and although it was not disgraced by being second to France in this group it is time that the Singapore team got out of the bottom group.

Tan Lian Ann feels that the erratic play of our team can only be overcomed if our players play regularly through the year. The intensive training which we went through a few months before the Olympiad did strengthen our game but only patchily and time and time again we made weak moves in good positions.

The Malaysian Team on the other hand is to be congratulated on a fine showing in its first appearance in the Olympiad. Dr. Foo Lum Choon played a true captain's role at Board one, bearing the brunt of the attack to lead his team to 12th place of fifteen teams in Group D.

Chess Olympiad, Skopje, 1972

Finals Group D: 1 France 46½; 2 Singapore 42½; 3 Malta 32; 4 Hongkong 30½; 5 Lebanon 30; 6 Luxemburg 29½; 7 Faroe Islands 29; 8 Syria 28;

9 Cyprus 27½; 10 Morocco 26; 11 Andorra 24; 12 Malaysia 23; 13 Guernsey 20½; 14 Iraq 20½; 15 Vergin Islands 10½.

We had hoped to beat France again as in Lugano 1968, but in vain. With Grandmaster Rossolimo at Board One, France crushed the opposition and round after round they scored the extra half point more than us. Even the loss of a match to Faroe Islands because of a misunderstanding which cost France two points by default did not prevent the French team by being four points ahead of Singapore at the end.

On the positive side, the Singapore Team showed its superiority over other group D teams by being 10½ points ahead of the Malta in third place. Tan Lian Ann met only two grandmasters in the 19 games he played. He drew with Anderson of Sweden, one of the best players in the world, and beat Rossolimo of France. The Singapore Team was the only unbeaten team in Group D.

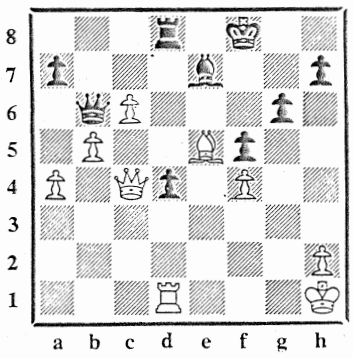
Some colleagues have complained about the poor publicity the Olympiad received locally. Although the organisation at Skopje was excellent, the bulletins giving the progress of the games were poorly done, and news agencies had to work hard to extract the information they wanted. Thus their cables dealt mainly with the events at the top and the fates of the smaller countries went unnoted. The mail service, too, was terrible, and my airmail-reports were being received as much as two weeks late.

Tan-Rossolimo (France)

1 e4 c5 2 Sf3 e6 3 d4 cd4 4 Sd4 Sf6 5 Sc3 Sc6 6 Sc6 bc6 7 Ld3 d5 8 0-0 Le7 9 Khl 0-0 10 f4 Sd7 11 ed5 ed5 12 Sa4 f5 13 c4 d4

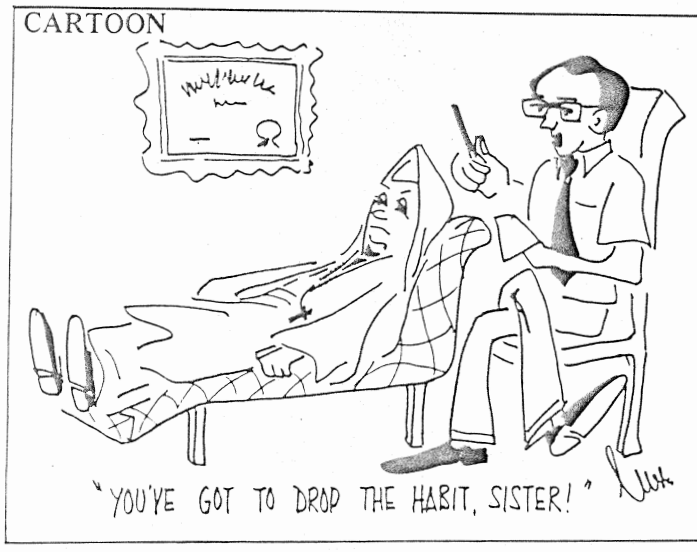
14 Dc2 Sb6 15 c5 Sd5 16 Ld2 Le6 17 Tae1 Dd7 18 b4 g6 19 Sb2 Sf6 20 Sc4 Ld5 21 Se5 Dc7 22 Sf3 Tad8 23 Sd4 Lg2 24 Kg2 Td4 25 Lc3 Tdd8 26 Lc4 Sd5 27 Tdl Tfe8

28 Le5 Db7 29 b5 Kf8 30 Ld5 Td5 31 Td5 cd5 32 a4 d4 33 c6 Db6 34 Tdl Td8 35 Dc4 (see diagram) Dc5 36 Td4 Td4 37 Dc5 Td2 38 Df2 Black resigned.



(In algebraic notation, S stands for Knight, L for Bishop, T for Rook, D for Queen and K for King. "Sd4" means Knight moves to or captures at d4; "d4" means pawn moves to d4; "cd4" means c-pawn captures on d4.)

CARTOON



SMA Congratulates

Elected F.R.A.C.P.
Dr. Beatrice T.M. Chen
Dr. Chew Loy Soong
Dr. Chua Kit Leng
Dr. Fung Wye Poh
Dr. F. Jeyaratnam
Dr. Johan bin Abdulla
Dr. Loong Si Chin

F.R.C.S. (Edin) Primary
Dr. Chan Ying Fatt
Dr. Ong Peck Leong

M.C.G.P. (Singapore)
Dr. Chang Ming Yu, James
Dr. Chin Keng Huat, Richard
Dr. Foo Choong Khean, Benny
Dr. Ho Leong Kit
Dr. Samuel, Frederick
Dr. Tan Swee Teck, Michael

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transplant kidneys, but to prevent them. The former is an "end of the road" approach. The general practitioners and government doctors should get together and work out a programme for early detection and treatment of renal diseases. A start has been made in Melbourne where all children with urinary infection were referred to a department in a local childrens' hospital, screened and then followed up with active treatment. A mass screening programme will be useful but will need massive organisation and finance, besides whole hearted co-operation from the population.

Finally, if one should fail in the control of pedestrians and early detection and treatment of patients with renal diseases, then as one cynic puts it "Never mind, we will have more donors for the increasing number of recipients."

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A Doctor's Point of View

the wishes of the relatives, and this is what part II of the new Medical (Therapy, Education and Research) Act seeks to protect. The new Act, based on the Uniform Anatomical Gift Act of the U.S.A., which is widely acclaimed and adopted by many states, has also taken the revolutionary step of clearly defining the classes of relatives in giving consent or objections to such a gift in order or priority. This is to ensure minimal delay in obtaining the gift, as there is always a time limit for the viability of an organ taken after death. The transplantation of a damaged organ is worse than no transplantation at all.

There has been criticisms on the Act in not providing adequate safeguard in three areas: (1) definition of death, (2) actual notice of recission or consent, and (3) the time span after which a body is deemed to be unclaimed and thereafter available for use for the purposes of the Act. Much that has to be said about the Act has been said in Parliament by the Minister for Health on the passing of the Act. Perhaps further explanation in these and other areas will help to alleviate the fear of possible abuse of the human body under the cover of this Act.

To determine death seems a simple procedure not too long ago. When a person appears lifeless with no breathing or heart beat, turns cold and stiff, he is dead. However, with the advance of modern medical science, and the invention of artificial means to maintain heartbeat and breathing, the definition of death becomes a difficult problem. It has been widely held that death has occurred if there is no spontaneous heartbeat or breathing for 10 minutes. This was found to be adequate until the advent of Heart-Lung machine and respirator. Nowadays, in surgery of the heart, it is necessary to stop the heart and breathing to allow operation to be performed on the heart and life is maintained artificially by the Heart-Lung machine. The operation may last a few hours during which there is no spontaneous heartbeat and breathing. Is the patient then dead? Yet he could be revived at the end of the operation. And in cases of severe head injuries, life could be maintained by the respirator without which death would ensue. The difficulty of determining when does death occur then arises.

The often quoted *Potter* case was reported in the *Medico-legal Journal* as follows:-

"An inquest was held in Newcastle on a man who fell backwards on to his head after being butted in a fight. About fourteen hours after admission to hospital he stopped breathing and was connected to an artificial respirator. Twenty-four hours later, with his wife's consent, a kidney was removed and grafted into another man. After the nephrectomy (removal of kidney) the respirator was disconnected and it was found that there was no spontaneous respiration or circulation of the blood. A medical witness said that the man had virtually died at the time when he was put on the respirator, although it would be legally correct to say that death did not occur until 24 hours later, when breathing and the heart beat had ceased."

The jury returned a verdict of manslaughter, and the coroner committed the assailant for trial. At the trial it was argued that the assailant did not cause the death of *Potter* but the act of switching off the respirator did. The assailant was eventually convicted of common assault. This has drawn a lot of comments notably that of Professor D.W. Elliot. He questioned "When is the moment of death?" and discussed the legal problems that can arise from such definitions. He had put forward a hypothetical case:

"After unjustifiable injuries have been inflicted upon him by *D*, *P* reaches this hopeless position on the first of the month, and is connected to an artificial respirator. On the 2nd, a surgeon *S*, obtains the consent of *P's* wife, *W*, to the removal of one of *P's* organs which is needed for transplanting in some other critically ill patient. *S* then removes the organ. On the 3rd, *S* discontinues the respirator and *P's* heart stops beating. Did *P* die on the 1st or 3rd of the month?"

If he died on the 3rd, the removal of the organ was unlawful without *P's* consent, and the act is both a crime (malicious wounding) and a tort (battery). *S* is guilty of homicide, which strictly speaking, is murder rather than manslaughter as death was foreseeable in switching off the respirator, so argued Professor Elliott. In fact, several surgeons in Japan and

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the U.S.A. had been brought to court on such charge. Further legal problems could arise such as:

"Did *P*, a legatee, survive a testator who died on the 2nd of the month? Did *P*, a joint tenant, survive his co-tenant who died on that day? Did *P*, a beneficiary with a contingent interest, survive until he attained a vested interest *(e.g.* by attaining his majority on the 2nd)? Did *P*, on whose death estate duty is payable, survive five years after making gifts *inter vivos?*"

These legal difficulties could be avoided if death is held to have occurred on the 1st when the hopeless situation is reached. But then it would be artificial to say of *P* that he is dead while the machine is in operation and life is maintained. Does it carry conviction to say of *P* "He died a fortnight ago, and we are using his body as a bank of live tissue?" So asked Professor Elliott.

Obviously there is a limit to when and how life should be maintained. People have always argued about the moral and ethical issue of switching off the respirator to allow life to extinguish. On the other hand, consideration should be given to the moral and ethical issue of maintaining a purely vegetative life by artificial means in cases of irrecoverable brain damage. Such cases have been maintained alive up to ten years and still remain in a deep coma. Without the artificial means they would be dead. The strain on the resources of the hospital, doctors, nurses and relatives is tremendous. Yet the medical profession is bound by the Hippocratic Oath to preserve life. But is vegetative life a 'true' life? There is also the practicality of freeing these life sustaining machines to help the more hopeful cases to recover and return to normal life. Then, with improvement of transplant techniques, the undamaged organs in these cases could be utilised to restore health and happiness to those patients that require them.

Thus there is an urgent need for the definition of death. This has been the subject of numerous congresses, symposia and articles. It is a complex problem but the focus is on the Electroencephalograph (EEG). This is a laboratory record of the electrical activity of the brain. Functioning brain activity is demonstrated by groups of wavy lines on tracing paper. If there is absence of brain activity, the tracing would be straight and termed an 'isoelectric or flat EEG'. This would indicate irreversible coma. But how long is 'sufficient period' and is it absolute? It has been shown that patients under deep anaesthesia, hypothermia or freezing of the body and in drug intoxication, the EEG can appear flat but these patients could be resuscitated subsequently. So in consideration of an isoelectric EEG these conditions must be excluded. However subsequent investigations show that by using a stricter criterion of isoelectric EEG, those cases that have recovered are not truly isoelectric but showed occasional low voltage activities, whereas in the truly 'flat' EEG, none of the patients survived.

However, the EEG is only part of the assessment of irreversible coma, as set out by the *Ad Hoc* committee of the Harvard Medical School to examine the definition of brain death. Should death be defined legally is the next question. The French Government had decreed a legal definition of death as "total absence of brain activity for a sufficient period", on April 24, 1968 to facilitate the first heart transplant in France. But the determination of the moment of death is a complex problem depending on clinical judgment and cannot be resolved by a single rigid legal definition when it suffers from cumbersome limitations and may be subjected to misinterpretation. The world opinion is that the determination of death is a clinical matter and should be left to the doctors, who will use a set of criteria to satisfy that life is truly extinct. Typically, it is contained in a statement issued by the World Medical Association in 1968, which reads:

"This determination [of the point of death] will be based on clinical judgment supplemented if necessary by a number of diagnostic aids (of which the electroencephalograph is currently the most helpful). However, no single technical criterion is entirely satisfactory in the present state of medicine nor can any one technological procedure be substituted for the overall judgment of the physician."

The Ministry of Health of Singapore has its own code of ethics stipulating that such death can be pronounced only after two senior doctors, one of whom must be a clinical consultant, had satisfied themselves that life is really extinct, using a number of criteria. And both these doctors must not be in any way responsible or participate in performance of the transplantation. This is in excess of the legal requirement as provided by the new Act. As the new Act deals with cases other than potential some and impractical in many cases, if stipulated by law.

Safeguard for the Individual

Since the will of the deceased person is held supreme over the wishes of all others by this Act, actual notice of donation or objection can be put in the form of a card to be carried on the person, as provided in section 9(c). It may be in the following form:

I ..... of .....
hereby do consent (or object) to give all or any part of my body for transplantation, education or research upon my death as provided in the Medical (Therapy, Education and Research) Act 1972.

Date .....
Signature .....

It has been suggested to keep a central register of all the possible donors and objectors so that these will be dealt with accordingly upon their death.

24 hours and the unclaimed body

It is the practice of the hospital that upon death of a patient, the relatives shall be contacted immediately, if necessary through the help of the police. In effect, 24 hours after death is very close to 24 hours after the information of death. Such bodies are only suitable for post-mortem examination to establish or confirm a cause of death, or to investigate normal or abnormal conditions. This is invariably done well after 24 hours after death because of required procedures to be complied with. Organs are not suitable for transplantation 24 hours after death. The establishment of a true cause of death could only be beneficial to the relatives.

Coroner's cases

In cases that fall under jurisdiction of the coroner, no such removal (of organs) or post-mortem examination shall be effected except with the written consent of the coroner. Here inter-disciplinary co-operation is needed. Since the removal of organs must await the consent of the coroner and the time factor in viability of organs for transplantation is all important, for example, to be useful for transplantation a kidney needs to be removed and cooled within one hour of death, the coroner must be present or immediately contactable when death is certified. This will entail the understanding and personal sacrifice of the coroner, as death can occur at odd hours. However, as Professor Roy Calne said:

"To see patients with good functioning renal transplants back at work and leading normal lives makes it clear that the effort is worth while".

The Act has set forth a new milestone in medico-legal practice, as it has expressed adequately the right of the individual to his body after death, so it shall not be inter-

● See page 8

News from the Council Table

YELLOW PAGES, SINGAPORE TELEPHONE DIRECTORY

Members are reminded that they are not permitted to pay for any insertion in the Yellow Pages of the Telephone Directory.

DINNER FOR PROF (SIR) GORDON RANSOME

Council decided to hold a subscription dinner for Prof. (Sir) Gordon Ransome on 16th January 1973. Members and guests are welcome. Further details will be announced in the usual SMA circulars.

MEDICAL ETHICS

(i) Professional Secrecy

No doctor is required to reveal the nature of his patient's illness to employers without the patient's permission.

(ii) Advertisement

No doctor should make any self-laudatory announcements of his medical achievements in any public function. Any claims of medical break-through should be reported only at closed scientific sessions when such claims could be carefully assessed by other workers.

DEFENCE UNION

Replies from the Medical Defence Union and the Medical Protection Society indicated that they were not prepared to change their decision of increasing the rate of subscription to $25 effective from January 1973. However, the latter agreed to review the matter after two years time.

Some established local insurance companies have been approached but all of them were not prepared to accept professional indemnity as this is generally considered a non-lucrative business.

About Skin

Some have thick skin,
Some, paperly thin.
Some skins are coarse and stony.
Like sands and stiff ebony.
Yet other skins are soft and supple
Satin-smooth and fur-like gentle,
A boon for aching vision;
A challenge to temptation.
Thus Beauty, Sex and Emotion
All a-mirrorr'd in its reflection.

Many a battle have been fought
Many a charmer's affection sought,
'Cause its texture and its shades
Weebit vary, of different makes.
'Tis strange how our lives and issues
Oft arise from tiny tissues.

Dr. Tay Chong Hai

EDITORIAL Cont'd from page 1

The Asian Pacific Congress of Cardiology

years) of an asymptomatic latent phase. This trend of picking out and treating diseases in the asymptomatic phase should be fully emphasized and reiterated, even at the expense of being accused by being repetitive. Risk factors for our local population should be identified and fully evaluated by the medical profession before being passed on as information to the general population.

However, much needs to be done in clearly outlining the natural history and patterns of cardiovascular disease in our region. Perhaps the Pediatric Department should be given credit for sorting out some of the problems, patterns and causes of congenital heart disease in Singapore. In acquired heart diseases many consultants and specialists in their fields do have some picture of the natural history of a particular type of heart disease of their speciality, but a fully organised study in all the major acquired heart diseases has yet to be undertaken and published. These basic norms of diseases have to be defined and established before sophisticated research on them can be carried out later. It is heartening to note that a research worker in adult medicine intends to study the incidence and natural history of rheumatic heart disease in Singapore. It is hoped that many similar projects are started to study the patterns of both congenital and acquired heart diseases in Singapore in conjunction with the general practitioner who sees the disease first in the asymptomatic phase and thus can help to construct the complete picture of a particular heart disease.

Other undoubted benefits of this conference include the opportunity provided for cross-fertilization of ideas, projects and studies. It also provided a unique opportunity of a close-up assessment and study of world famous figures in the realm of cardiology, so that one can get a truer picture of their works and their intrinsic worth. To the younger and financially poorer asian research worker this conference was a real boon, for, with a minimal outlay of money, he was provided with a rare opportunity of meeting all the world's leading figures in cardiology, as compared to the larger sums of money he would have to spent to travel to Europe and America where these conferences are usually held.

By and large it can be said that the medical profession has benefited a great deal by this cardiac conference; however it yet to be seen, if the general population will maximally benefit from the full array of new trends in cardiology, preventive and surgery. Given the enthusiasm and the organisation there can be no doubt this will ultimately result. Can we as a profession get together and discuss how to implement this?

Cont'd from page 7

fered with by the relatives. Further, it has stated clearly the priority of the relatives giving consent or objections. This is a major step forward in an attempt to solve many of the legal uncertainties, at the same time not to intrude upon matters which require medical judgement. This is hoped to bring about more donors for life-saving transplantations, as well as to provide adequate safeguards for the individual.

(Reprinted from Malayan Law Journal)

Season's Greetings

The President & Council of the Singapore Medical Association extend their Season's Greetings and Best Wishes to all S.M.A. Members.

LETTERS (Not to be quoted in the Press)

Dear Sir,

I reply to your reply to my letter on SMC representation.

One is naturally pleased to learn that, thanks to your last minute act of magnanimity, my contribution had been spared the ignominy of ending up in your clinic's dustbin together with your soiled swabs and discarded dressings.

Unfortunately, the same cannot be said of your condescension in granting that our members are sophisticated and discriminative enough to be the best judges of what they read. Many of our members were already practising medicine long before some of us were even born. Their sophistication and discrimination should have been taken for granted. Nothing is more pompous and offensive than flattery of the obvious.

Moreover, doctors should be entitled to read every contribution to the Newsletter of the SMA so long as it is not personal, libellous, offensive or subversive. You should regard this as the basic right of members of the SMA and not as a favour granted to them for having attained the Age of Sophistication and Discrimination.

Finally, allow me to refer to your last sentence which categorically stated that I 'invariably use every available opportunity to express my political views in one form or another'.

Your statement is totally irrelevant since it has got nothing whatever to do with my views on SMC representation. Your statement is also very personal, and borders on the libellous. You will have great difficulty in substantiating what you have so frivolously charged. What is even more distressing is that you and your editorial board do not seem to know the difference between a political propagandist and a social critic.

All that I did in my letter was:

Firstly, to dismiss, as sheer fantasy, your alarmist report of the potential dangers of a take over bid of the SMA.

Secondly, to advise you, as the responsible editor of the medical profession, not to join the ranks of those who perceive subversion in every disagreement with official policy.

I frankly cannot see anything political or sinister in such views. I think the same can be said of all my other contributions to the previous Newsletters. These surely are views shared by every one who loves Truth and values Freedom of Expression, irrespective of his political affiliations.

In spite of your abortive attempt to ban my letter, I have no doubt that you and members of your editorial board fully deserve to be counted among this group of enlightened people – if only you will encourage more expression of original views and practise less suppression of controversial issues.

Dr. Un Hon Hing.

Editorial Board Statement.

The Editorial Board wishes to reiterate that the cardinal factor in its policy determinants is that the contents of the Newsletter should not only be consonant with the aims and objectives of SMA but also endeavour to reflect and enhance the collective aspirations and will of the Association members.

The writer appears to be under some misapprehension that we are out to suppress his article or views. Though the tone and manner of his letters leave much to be desired the publication of his two letters itself shows that his fears are not justified.

However, we do not share his views that this Editorial Board should merely act as clerical clearing houses by excluding personal, libellous, offensive or subversive material.

Though his accusations can be rebutted in an itemised manner, we feel that by so doing no useful purpose would be achieved in the interests of SMA. We would rather leave it to our readers to judge for themselves. Further correspondence on this subject is closed.

Who's Swimming in the Alumni Pool?

Dear Sir,

It has been brought to the notice of the Committee that members of Singapore Medical Association and its affiliated societies who are not members of the Alumni Association have been using the swimming pool.

The Committee has instructed me to extend an invitation to all members of SMA and its affiliated societies to join the Alumni Association and enjoy the facilities herein provided.

Yours sincerely,
ALUMNI ASSOCIATION
Southern Branch

(Dr. Lim Kuang Hui)
Hon. Secretary

SMA Squash Squad Scores!

While some members are making headlines in the Academic, Political and even Social circles, some of our Squash playing members got together and made an impact on the Singapore Squash Scene. These members got together and entered as a team (under the banner of the SMA) in the 1972 Singapore Squash 'C' Grade League Championship, and emerged champions. In the grand finals played on Wednesday 11-10-72 at the Tanglin Club our team defeated the Police 2nd Team (who were last year's champions) by 3 games to 1. This victory was the more significant because it is the first time that our Association has taken part and won in competitive Squash. In fact it is probably the first time that our Association has won any sporting event in Singapore! The members of the victorious team were (in order of placing):-

1. Teoh Hoon Cheow (Vice-Captain)
2. David Yeo (Captain)
3. Chong Kwang Dick
4. Albert Wee
5. Mah Guan Kong
6. Edwin Yip

In addition to being the League Champions in the 'C' Grade our players also fared well in the 1972 Pesta Sukan Individual 'C' Grade Squash Championship – particularly our top player Teoh Hoon Cheow who captured the championship title in the grade. Two other players Chong Kwang Dick and Albert Wee also took the winner and runner-up medals respectively in the 'C' Grade Plate Competition. Our team captain David Yeo was a semi-finalist in the 'C' Grade competition and was unlucky not to have qualified for the finals against Teoh.

It is hoped that these victories by our boys will generate some interest in the game among our members – not only among those who are already playing the game for recreation but the others who have never stepped into a Squash Court either as a player or spectator. Perhaps the day is not too far off when we can have our own Squash Courts where members can congregate to play and train with each other. And, who knows, the SMA may produce one of the top Squash Teams in Singapore in the not too distant future!

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